CSHP

Rutgers Center for State Health Policy

State Policy, Health Care Disparities, and the Invisible Hand of the Market

State Health Research and Policy Interest Group - Poster Session
Academy Health Annual Research Meeting
June 7, 2008
Washington DC

Joel C. Cantor,* Michael Yedidia*, Derek DeLia*,

Karl Kronebusch^, Amy Tiedemann*

*Rutgers Center for State Health Policy & ^Baruch College

Funded by AHRQ, Grant #R01-HS014191

Background

New Jersey Certificate of Need (CON) reforms sought to increase *access* and maintain *quality* in diagnostic cardiac catheterization (CATH)

- Doubled the number of CATH facilities
- Strict quality regulations
- Incentives to reduce disparities

The New Jersey CON reforms

1996	- Two-year CON pilot program for low-risk CATH patients - Minimum volume & maximum % negative rules - Community Outreach/Access Plans required - Audited clinical data reporting
1998	- Low-risk CATH pilot extended - Disparity reduction criteria for *cardiac surgery* CONs - CON no longer needed for expansion of full-service CATH - Full service CATH facilities may "graduate" to cardiac surgery
2001	- Low-risk CATH program made permanent - Low-risk CATH facilities may "graduate" to full service

Study Design

Compare trends in CATH utilization rates for "incumbent" and "new" facilities

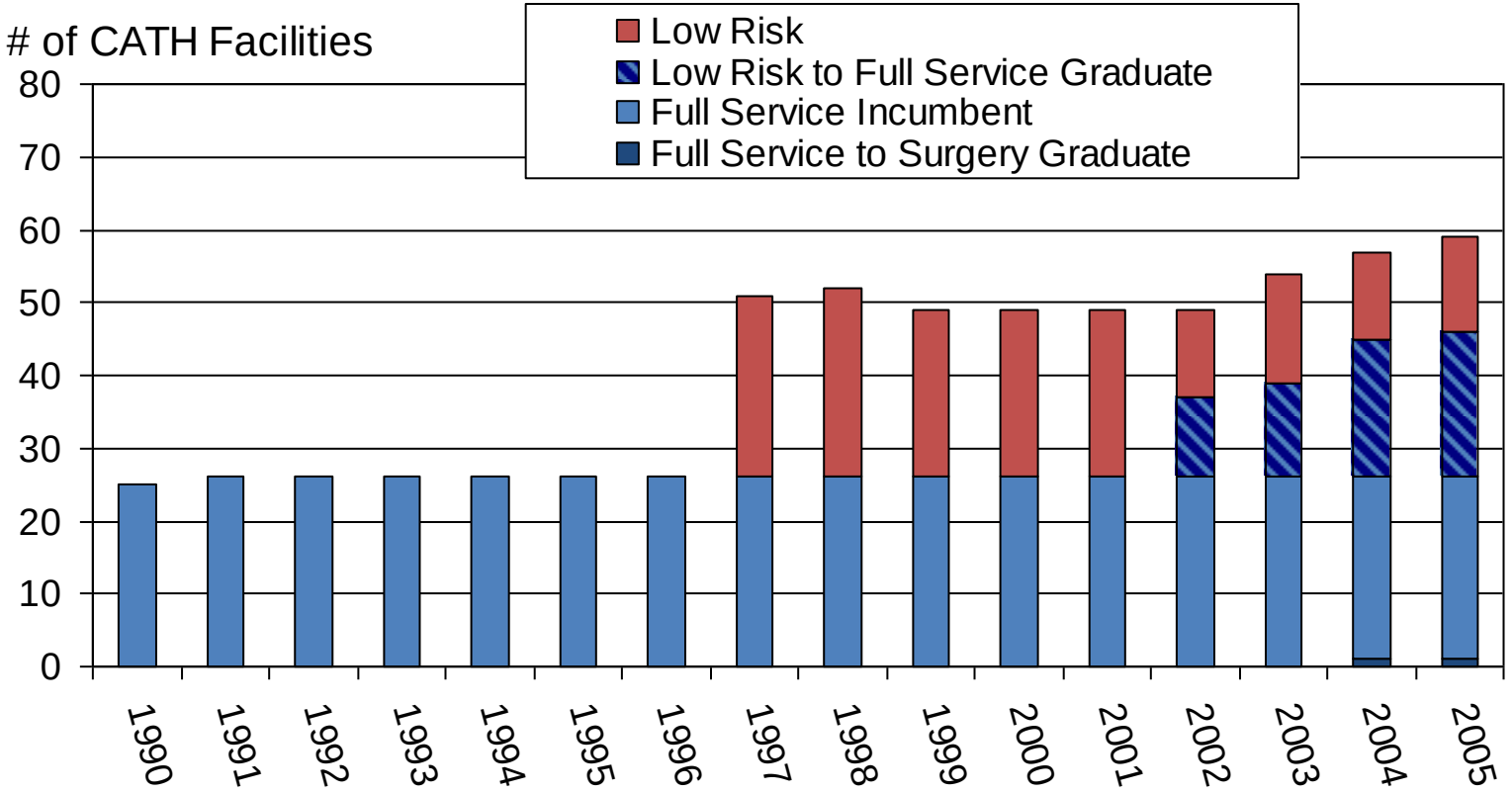
Semi-structured interviews with policy stakeholders (June-July 2005)

- 5 current regulatory officials/advisors
- 3 former regulatory officials
- 2 senior non-governmental stakeholders

Semi-structured interviews with hospital officials (Summer 2007)

- Seven clinical staff and senior officials from three hospitals with increased percentage of black CATH patients

Number of facilities more than doubled & many have graduated to full service



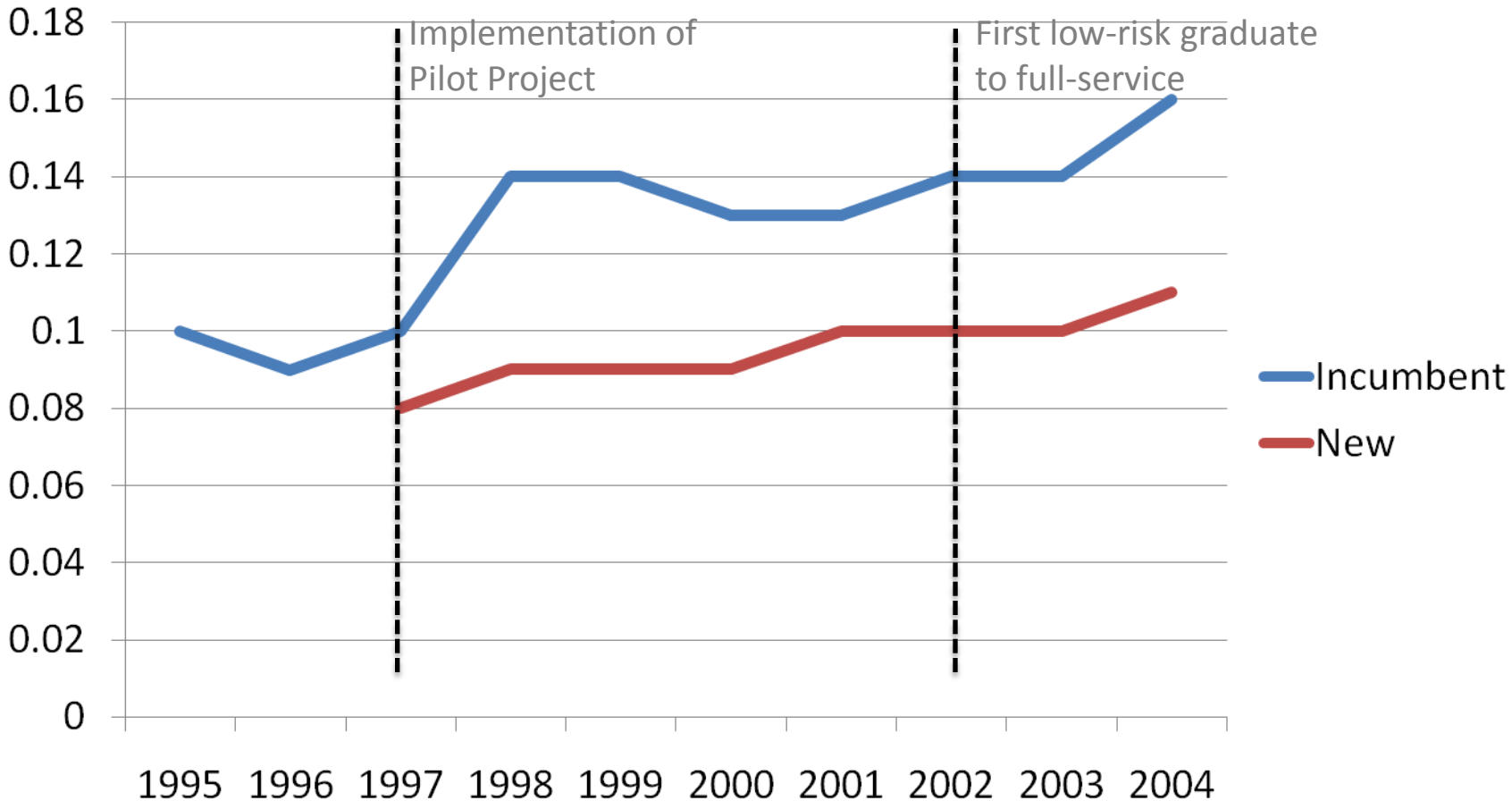
Source: NJDHSS Regulatory Reports

New CATH hospitals smaller, lower-tech, not located in areas with many blacks

	INCUMBENT Facilities	NEW Facilities	No CATH Facilities
% African American/ in market area	15%	13%	18%
Mean # staffed beds	405	293	174
% with Teaching	37%	5%	0%
# high-tech services (0 to 7)	2.47	0.75	0.33

Sources: NJ hospital discharge abstract data and AHA Annual Survey, 1999

Ratio of black to white CATH patients rose steeply in "incumbent" facilities



Sources: NJ hospital discharge abstract data (UB-92)

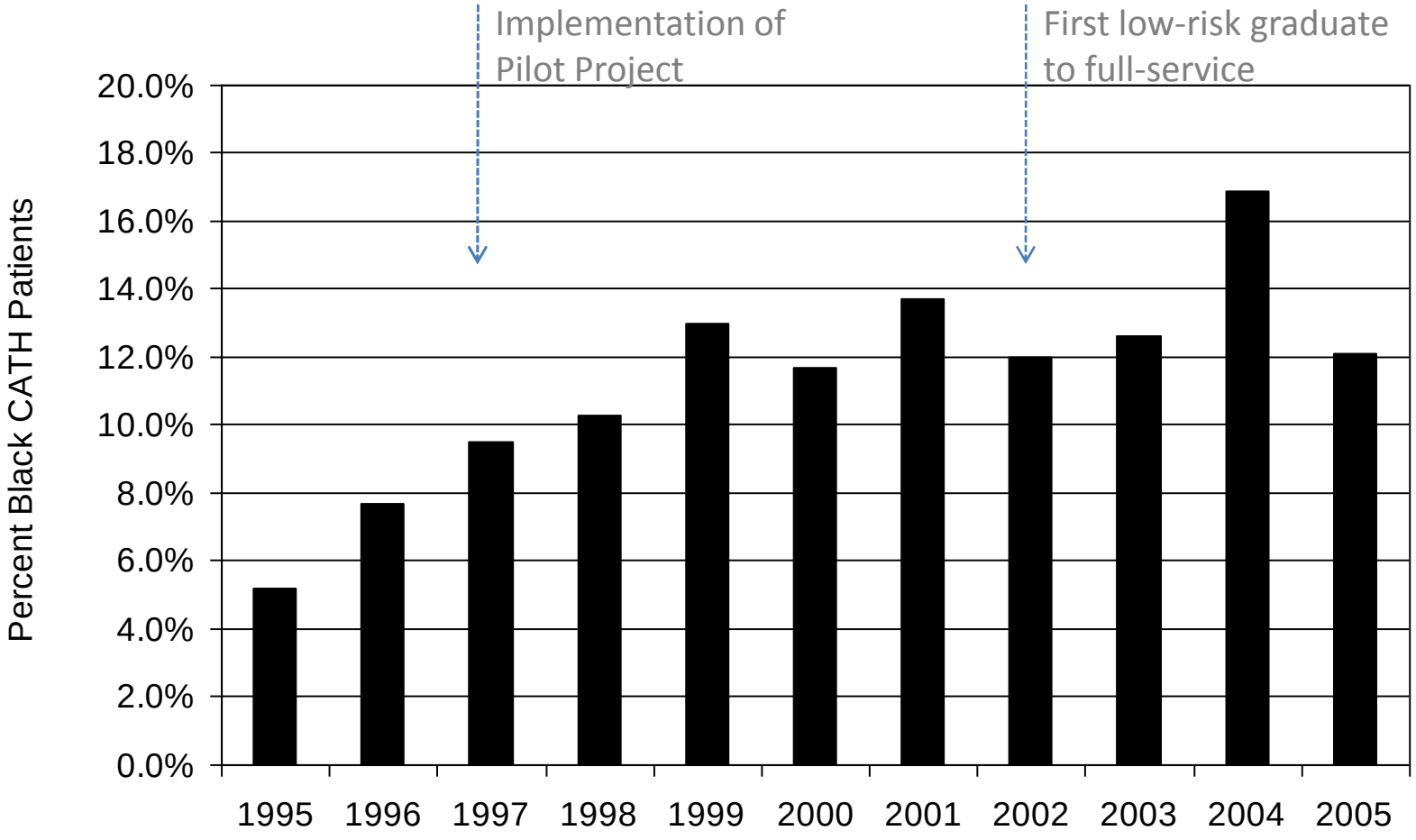
Policy Formation:
Observations from Regulatory Stakeholders

- Hospitals very eager to provide CATH, seen as gateway to profitable services, great pressure to ease CON rules
- Pro-market ideology among senior advisors to Governor
- Regulatory officials committed to CON…
  - Feared over-use and quality problems
  - Believed minority patients had poor access
- Commissioner of Health sought middle path…
  - Increase CATH capacity on pilot basis, strict quality checks
  - Explicit focus on disparity reduction

Policy Implementation:
Observations from Regulatory Stakeholders

- Difficulty establishing concrete disparity reduction goals
  - Hospitals could select any 'underserved' group in Outreach & Access plan
  - No consensus on measurement
- CON regulatory enforcement focused on quality (minimum volume, % negative) rules
- Outreach & Access plan requirement seen as weak, applied only to newly licensed facilities, not enforced
- Ambitions to provide full-service CATH or cardiac surgery *may* provide incentive to improve minority access

CASE STUDY HOSPITAL #1



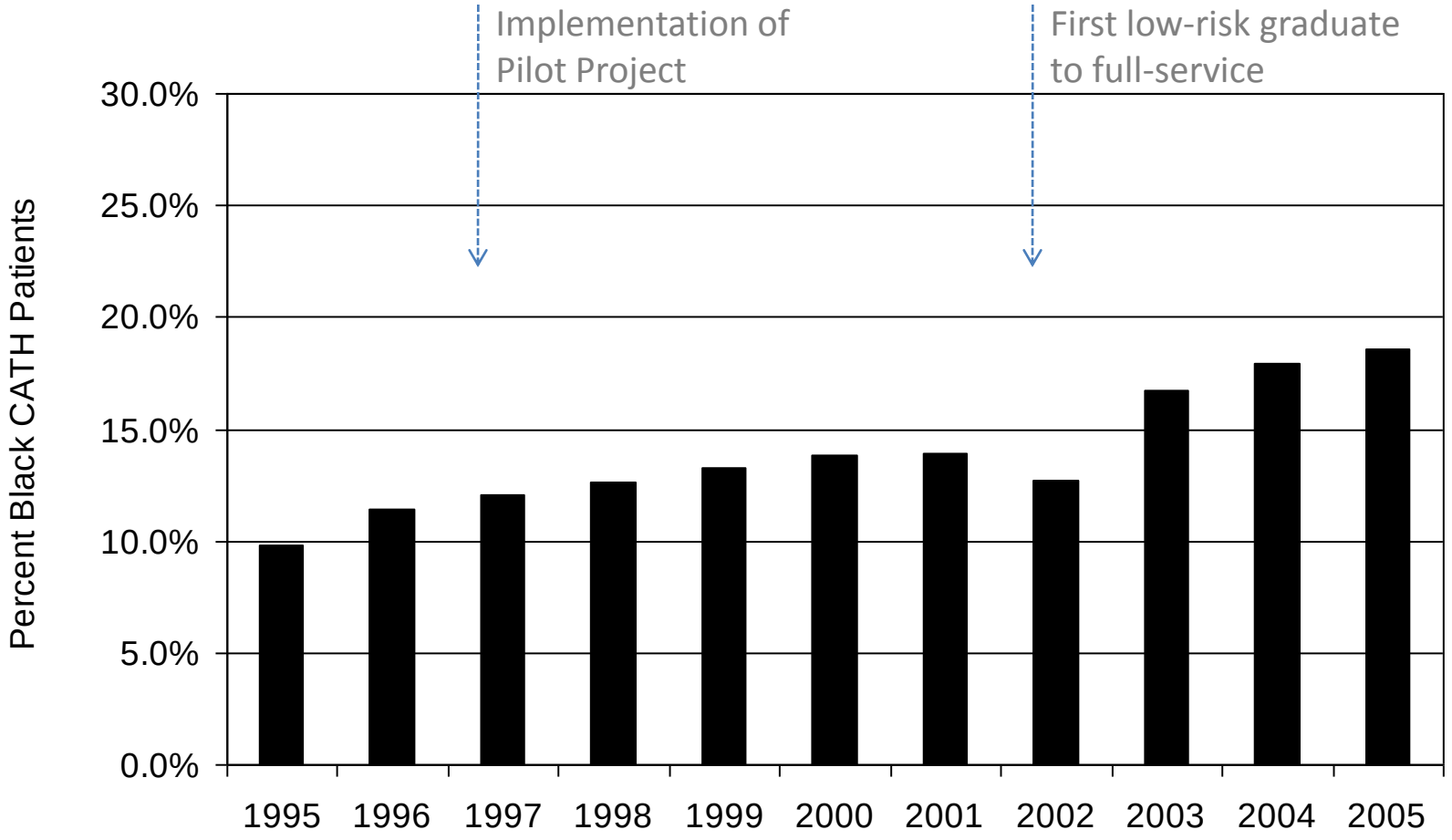
Source: NJ DHSS UB92 Hospital Discharge Billing Records

CASE STUDY HOSPITAL #1

600+ bed non-profit, system flagship hospital, 15% Medicaid or uninsured. Both total volume and the percent black patients increased after the reforms.

"I have no idea [why the proportion of black cardiac angiography patients has gone up], unless the local demographics are shifting. I hadn't noticed a trend like that, but of course, we don't look at our numbers like that." -- Chief of Cardiology

CASE STUDY HOSPITAL #2



Source: NJ DHSS UB92 Hospital Discharge Billing Records

CASE STUDY HOSPITAL #2

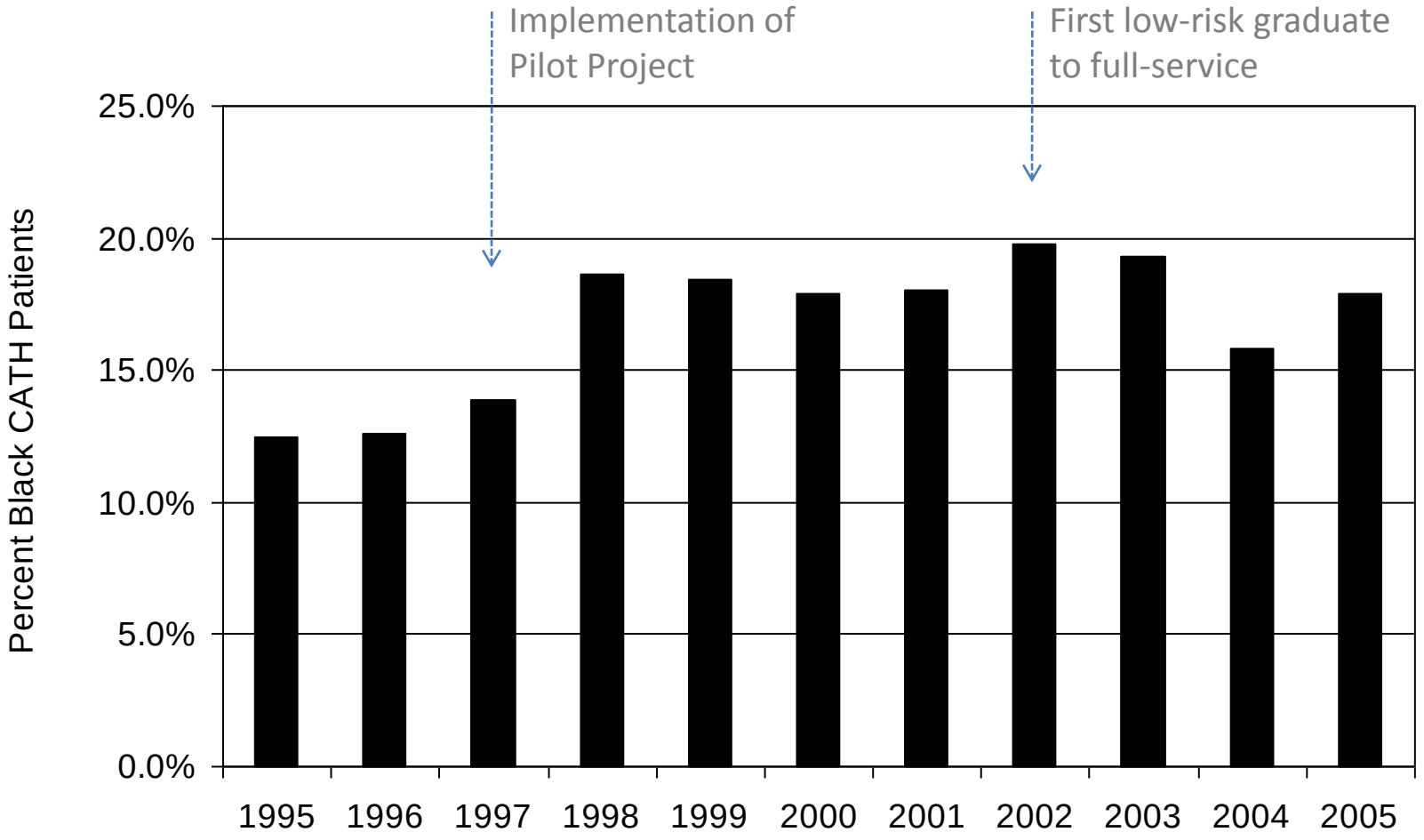
500+ bed, non-profit safety net hospital, 40%+ Medicaid or uninsured. New low-risk facility opened nearby in the early 2000s.

"…we had a drop [in volume] because [a nearby] hospital opened a [new low-risk] cath lab. [Since then] the volume is increasing. For blacks, health care is very poor and obesity is very high. Diabetes is very high. Hypertension is very high. They get these at a young age, and as a result of that, coronary disease is increasing." -- Director of Cardiac Cath Lab

"Over the years, [our] hospital has gotten progressively better at [serving] minority groups, moving them through the system, [with] more advocacy."

-- Manager of Cardiac Cath Lab

CASE STUDY HOSPITAL #3



Source: NJ DHSS UB92 Hospital Discharge Billing Records

CASE STUDY HOSPITAL #3

400+ bed, major urban teaching center, 40% Medicaid or uninsured.

Total CATH volume decreased in the late 1990s when a high-volume cardiologist with a mainly suburban clientele left. A new chief of cardiology was recruited.

"[Our new affiliated cardiology practice] draws more from the local community than [did the former] cardiology [practice]…. When the volume converted to being more [from the new affiliated practice]…, we were seeing more area patients, which may explain the increase [in black patients]…. I think that's the best interpretation of this data. But again, we've never looked at this, so this is new to us."

-- Assistant VP of Cardiology

Conclusions

- **Regulations directed at disparities (e.g., Outreach & Access plans) appear ineffective**
  - Newly licensed facilities not located in markets with disproportionate number of blacks
  - Regulations seen as weak, not enforceable
- **Disparities reduced by "incumbent" facilities**
  - New competition for largely white, well-to-do patients from suburban hospitals
  - Increased services to black patients
  - Hospital leaders had difficulty articulating causes of change but they appeared to be market driven

Policy Implications

- **Direct regulation to reduce disparities may be difficult**
  - Outreach & Access requirement apparently failed
- **Limiting hospital service capacity may exacerbate disparities**
  - Strict limits may enable facilities to limit service to most financially attractive patients
  - Awarding CON franchises to “safety net” hospitals no guarantee that access for underserved will be improved
  - Market incentives are a possible tool for disparity reduction
- **Tradeoffs inherent in goals of achieving high quality, limiting over-utilization, and reducing disparities**